No. 98-1949

IN THE

Supreme Court of the United States

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION and HEALTH ALLIANCE MEDICAL PLANS, INC.,

Petitioners,

v.

CYNTHIA HERDRICH,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION

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PARTIES TO THE PROCEEDING

Carle Clinic Association, P.C. is an Illinois professional corporation comprised of licensed physicians, dentists and podiatrists. Health Alliance Medical Plans, Inc. is a for-profit Illinois domestic stock insurance company and is a wholly-owned subsidiary of Carle Clinic Association, P.C. (App. 42a). Carle Health Insurance Management Company is a for-profit Illinois corporation and is a wholly-owned subsidiary of Carle Clinic Association, P.C. (App. 42a).

These three entities file consolidated income tax returns. (App. 44a). Pursuant to Article III, Section 2 of Health Alliance's corporate by-laws, an appointment to the Board of Governors of Carle Clinic Association, P.C. results in an automatic appointment to the Board of Directors of Health Alliance. (App. 45a).

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STATEMENT OF THE CASE

In March of 1991, petitioner Lori Pegram, respondent Cynthia Herdrich's doctor, discovered a 6 x 8 centimeter "mass" (later determined to be her appendix) in respondent's abdomen. 154 F.3d 362, 374. Although the mass was inflamed on March 7, Pegram delayed instituting immediate treatment of Herdrich, and forced her to wait more than one week (eight days) to obtain the accepted diagnostic procedure (ultrasound) used to determine the nature, size and exact location of the mass. Ideally, Herdrich should have had the ultrasound administered with all speed after the inflamed mass was discovered in her abdomen in order that her condition could be diagnosed and treated before deteriorating as it did, but respondents' policy requires plan participants to receive medical care from Carle-staff facilities. *Id.* Respondent was forced to wait the eight days before undergoing the ultrasound at a Carle facility in Urbana, Illinois. During this unnecessary waiting period, Herdrich's health problems were exacerbated and her appendix ruptured, resulting in the onset of peritonitis. In an effort to defray the increased costs associated with the surgery required to drain and cleanse Herdrich's ruptured appendix, Carle insisted that she have the procedure performed at its own Urbana facility, necessitating that Herdrich travel more than fifty miles from her neighborhood hospital in Bloomington, Illinois. *Id.*

Respondent Herdrich filed a two count complaint in State court on October 21, 1992. (App. 5a). Count I alleged medical negligence against petitioner Lori Pegram for failing to adequately examine, treat, and follow-up on respondent's complaint of right, lower quadrant pain. She claimed that Pegram's failure to employ the skill and care ordinarily used by a reasonably well-qualified physician resulted in a

ruptured appendix, which caused peritonitis. Count II sought to hold Carle Clinic Association liable under the theory of respondeat superior. Pegram and Carle Clinic filed an Answer to the State court complaint on December 8, 1992. (App. 6a).

Because it appeared that all the decisions as to respondent's treatment could be explained on the basis of petitioners' profit motive, respondent filed an addendum to her State court complaint in February 1994, adding Counts III and IV. Count III alleged that Carle Clinic failed to disclose certain material facts regarding the ownership of Health Alliance Medical Plans in violation of the Illinois Consumer Fraud Act, 815 ILCS 505/1 *et seq*. Count IV charged Health Alliance breached its duty of good faith and fair dealing. (App. 6a).

The petitioners filed a Notice of Removal on March 14, 1994, asserting that Counts III and IV were preempted by the Employees Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1101, and that the pendant state claims set forth in Counts I and II were removable pursuant to 28 U.S.C. § 1367. Respondent filed a Motion to Remand on April 8, 1994. (App. 6a).

In opposition to the Motion to Remand, petitioners argued that Counts III and IV related to the administration of a Plan and were thus preempted under ERISA. Specifically, petitioners set forth a Synopsis of Relevant Facts which stated that Herdrich was a participant and beneficiary in an employee benefit plan ("the Plan") provided to her through her husband's employer, State Farm Insurance Companies. ***Petitioner's factual synopsis also asserted that Health Alliance was the administrator and fiduciary of the Plan***. In their memorandum in opposition to respondent's motion to remand, petitioners stated:

> The plaintiff, Cynthia Herdrich, was a participant and beneficiary in an employee benefit plan ("the Plan") provided to her by her husband's employer, State Farm Insurance Companies. ***Defendant, Health Alliance Medical Plans, Inc. ("Health Alliance") was the administrator and fiduciary of the Plan within the meaning of ERISA (29 U.S.C. Section 1001 et seq.)***

(App. 24a).

* * *

> In the case now before this Court, it is clear that the plaintiff's claims relate to the Plan administered by Health Alliance. The relationship between the plaintiff and Health Alliance arose solely from the Plan. ***But for the existence of the Plan, Cynthia Herdrich's participation in that Plan and Health Alliance's serving as administrator/fiduciary of that Plan, there would be no relationship whatsoever between Cynthia Herdrich and Health Alliance and thus no lawsuit***.

(Emphasis added) (App. 36a).

This case was initially filed in state court. It was petitioners that sought and obtained removal to federal court. It was petitioners that sought and obtained a ruling that they were fiduciaries under ERISA. It was petitioners that sought

and obtained a ruling that ERISA governs this action. After seeking and obtaining these rulings, petitioners now argue that they are not fiduciaries, and that this action should not be governed by ERISA.

A. The Petition Mischaracterizes the Ruling of the Court of Appeals

Petitioners argue that the Court of Appeals "determined that the bare allegations that petitioners implemented cost-containment mechanisms that included potential rewards for physicians based on the Plan's financial performance sufficed to state an ERISA claim for breach of fiduciary duty." (Pet. 7, 9) Petitioners further assert that the "issue in this case is whether employer-sponsored health plans governed by ERISA may use the commonplace mechanisms for financing and delivering health care for their participants and beneficiaries," (Pet. 14) and that, if the Court of Appeals' decision is accepted, then "the principal organizational forms through which medical care is delivered today are unlawful." (Pet. 15).

These arguments completely mischaracterize the ruling the Court of Appeals. The Court of Appeals explicitly stated that its decision does ***not*** stand for the proposition that the existence of incentives automatically gives rise to a breach of fiduciary duty:

> The dissent disagrees with this aspect of today's holding, which it characterizes as concluding that "the mere existence of this asserted conflict [*i.e.*, the conflict between the incentive scheme for Carle doctors to limit medical care and treatment, on the one hand, and the fiduciary duty of Carle

> to the beneficiaries, on the other], without more, gives rise to a cause of action for breach of fiduciary duty under ERISA." ***That is not the conclusion we reach. Our decision does not stand for the proposition that the existence of incentives automatically gives rise to a breach of fiduciary duty.*** Rather, we hold that incentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (i.e., where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses.)

154 F.3d 362 at 373 (emphasis added). The Court of Appeals went on to say:

> The dissent also stresses that ERISA allows fiduciaries to adopt dual loyalties, and that maintaining dual loyalties does not in itself constitute a breach of fiduciary duty. We do not disagree with this contention, for it is well established that dual loyalties are tolerated under ERISA. *See, e.g.*, *Donovan v. Bierwirth*, 538 F. Supp. 463, 468 (E.D.N.Y. 1981). Our point is not that a fiduciary may not have dual loyalties; it is that the tolerance of dual loyalties does not extend to the situation like the case before us where a fiduciary jettisons his responsibility to the physical well-being of beneficiaries in favor of "loyalty" to his own financial interests. Tolerance, in other words, has its limits.

Id.

Petitioners also argue that the Court of Appeals stretched "the definition of a 'fiduciary' under ERISA," in order to hold that "health plans which include incentives to health care providers to contain costs are unlawful." (Pet. 9). Not only do these arguments mischaracterize the ruling of the Court of Appeals, they also completely ignore the fact that petitioners removed this case to federal court; that petitioners claimed to be fiduciaries under ERISA; and that petitioners argued that this case was governed by ERISA. Petitioners, at this point, are essentially arguing with themselves. Petitioners invoked federal jurisdiction and argued ERISA preemption in order to vitiate respondent's common law and statutory claims. After having been accommodated in their requests, petitioners are now arguing that they are not ERISA fiduciaries and that this action is not governed by ERISA!

Petitioners further argue that it is ironic that this ruling involves a physician-owned HMO because physicians cannot allow financial incentives to hinder patient care in light of the American Medical Association's *Principles of Medical Ethics* (1994). (Pet. 10). This argument firstly assumes that petitioners adhere to the AMA's principles of medical ethics, a fact upon which there has been no proof. But more importantly, the courts examining this issue have not found that the AMA's proscriptions afford patients adequate protection. In *Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748 (D.C.N.Y. 1997) the court held that an HMO's "gag order" violated ERISA's fiduciary duties and stated:

> It is true that a physician has an independent duty to provide full information to his or her patients, a duty which "is not altered by limitations in the coverage provided by the patient's managed care plan." (*See* Council on Ethical and Judicial Affairs, American Medical Association Ethical Issues in Managed Care, Council Report, 273 JAMA 330 (Jan. 25, 1995)). A patient therefore cannot be deprived of such information absent an ethical breach on the part of the physician. Nonetheless, CIGNA's alleged rule mandating such an ethical breach upon pain of termination would provide many physicians with no meaningful choice and would effectively limit the amount of information available to Plan participants.

Weiss at 752.

B. The Petition Mischaracterizes the Allegations of the Amended Complaint

Petitioners argue that, in Count III of her complaint, Herdrich alleged that petitioners breached their fiduciary duty under ERISA by establishing a cost-containment mechanism which provided physicians with a "year-end distribution" based on the savings achieved by cost-containment, (Pet. 15) and that therefore, the Court of Appeals' essential holding is that ERISA health care plans "have a fiduciary duty not to adopt HMO(s) or other managed care options because cost-containment incentives create a conflict of interest for the health care provider." (Pet. 9). But the Court of Appeals did not hold, and respondent did not allege, that cost-containment incentives, standing alone, constitute a breach of ERISA fiduciary duties. Rather, respondent alleged, in great detail, that here the particular corporate structure between the medical clinic (Carle Clinic), the insurance company (Health Alliance), and the individual physician-owners, created a conflict of interest. Due to this

peculiar corporate structure, the primary care physicians and the insurance company offering the HMO are the alter egos of Carle Clinic. Carle Clinic and Health Alliance file consolidated income tax returns. (App. 44a) Appointment to the Carle Clinic Board of Governors results in an automatic appointment to the Health Alliance Board of Directors. (App. 45a) Health Alliance is a for-profit Illinois stock insurance company, 100% of which is owned by Carle Clinic. The physicians, as owners of 100% of the stock of Health Alliance, not only employ themselves, but also completely control the claims processing and utilization review functions of Health Alliance. Respondent did not allege the mere existence of cost containment incentives. Respondent alleged:

> 6. Prior to March of 1991 and annually thereafter, for valuable consideration, through State Farm, defendants sold plaintiff a subscription in CARLE CARE HMO, a pre-paid health insurance plan (hereinafter "the Plan") arranging medical and hospital services for subscribers (see attached Exhibit A).
>
> 7. State Farm retained no right to direct or control the administration of the Plan.
>
> 8. Defendants have the exclusive right to decide all disputed and non-routine claims under the Plan.
>
> 9. Under the Plan, defendants exercise discretionary authority and discretionary control of claims management, property and asset management, and administration of the Plan.

> 10. Defendant [sic] is a participant and beneficiary under the Plan and brings this action on behalf of the Plan pursuant to 29 USC 1132(a).
>
> 11. Defendants are fiduciaries with respect to the Plan and under 29 USC 1109(a) are obligated to discharge their duties with respect to the Plan solely in the interest of the participants and beneficiaries and
>
> (a) for the exclusive purpose of:
>
> (i) providing benefits to participants and their beneficiaries; and
>
> (ii) defraying reasonable expenses of administering the Plan;
>
> (b) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and like aims.
>
> 12. In breach of that duty:
>
> (a) CARLE owner/physicians are the officers and directors of HAMP and CHIMCO and receive a year-end distribution, based in large part upon, supplemental medical expense payments made to CARLE by HAMP and CHIMCO;

(b) Both HAMP and CHIMCO are directed and controlled by CARLE owner/physicians and seek to fund their supplemental medical expense payments to CARLE:

(i) by contracting with CARLE owner/physicians to provide the medical services contemplated in the Plan and then having those contracted owner/physicians;

(1) minimize the use of diagnostic tests;

(2) minimize the use of facilities not owned by CARLE; and

(3) minimize the use of emergency and non-emergency consultation and/or referrals to non-contracted physicians.

(ii) by administering disputed and non-routine health insurance claims and determining:

(1) which claims are covered under the Plan and to what extent;

(2) what the applicable standard of care is;

(3) whether a course of treatment is experimental;

(4) whether a course of treatment is reasonable and customary; and

(5) whether a medical condition is an emergency.

13. As a direct and proximate result of defendants' breach of their fiduciary duties, the Plan has been deprived of those sums comprising the supplemental medical expenses made by HAMP and CHIMCO to CARLE, as well as those amounts which would have been realized by prudently investing those supplemental medical expenses.

Petitioners implore this Court to ignore the fact that respondent's allegations were very fact-specific, and to ignore the fact that the ruling of the Court of Appeals was very fact specific.

REASONS FOR DENYING THE WRIT

ERISA is a statutory scheme which regulates all "private employee benefits plans, including both pension plans and welfare plans." *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 127, 113 S. Ct. 580, 582, 121 L. Ed. 2d 513 (1992). The definition of a "welfare plan" includes "any plan, fund, or program" maintained for the purpose of providing medical or other health benefits for

employees or their beneficiaries "though the purchase of insurance or otherwise." *Id.* (quoting 29 U.S.C. § 1002(1)). ERISA establishes uniform standards, including rules relating to "reporting, disclosure, and fiduciary responsibility." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137, 111 S. Ct. 478, 482, 112 L. Ed. 2d 474 (1990).

In order to properly state a claim for breach of fiduciary duty under ERISA, a complaint must allege facts which set forth: (1) that the defendants are Plan fiduciaries; (2) that the defendants breached their fiduciary duties; and (3) that a cognizable loss resulted. *See* 29 U.S.C. § 1104(a).

ERISA defines the term "fiduciary" in 29 U.S.C. § 1002(21)(A), which reads, in relevant part:

> Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority of control respecting management or disposition of its assets . . . or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

Congress, when it enacted ERISA, intended that this statutory definition of "fiduciary" be broadly interpreted. As stated by the Chairman of the House Committee on Education and Labor, 120 Cong. Rec. 3977, 3983 (February 25, 1974), *reprinted*, 2 Legislative History of the Employee Retirement Income Security Act of 1974 at 3293:

> The Committee has adopted the view that the definition of fiduciary is of necessity broad . . . A fiduciary need not be a person with direct access to the assets of the plan. . . Conduct alone may in an appropriate circumstance impose fiduciary obligations. It is the clear intention of the Committee that any person with a specific duty imposed upon him by this statute be deemed to be a fiduciary . . .

I.

THE PETITION OVERSTATES THE IMPORTANCE OF THE NARROW HOLDING BELOW, WHICH DOES NOT SQUARELY PRESENT THE QUESTION ON WHICH REVIEW IS SOUGHT.

A. Petitioners Failed To Preserve Their Arguments In The Courts Below

In opposing Herdrich's appeal to the Seventh Circuit, Petitioners did not argue, as they now do in their petition for writ of certiorari, that there was no breach of fiduciary duty. Rather, petitioner's argued firstly that there was no appellate jurisdiction and secondly, that Herdrich had not established that petitioners were fiduciaries. Indeed, in opposing Herdrich's appeal to the Seventh Circuit, petitioners argued that there was no need to even discuss the issue of cost containment incentives, arguing that that question was "inappropriate at this stage of the litigation." At no point during the initial appeal did petitioners argue 42 U.S.C. § 300(e) (enabling legislation) or 42 C.F.R. § 417.479 (Medicare and Medicaid regulation). Quite to the contrary, petitioners argued that this was a case of first impression.

Petitioners did not make any arguments concerning 42 U.S.C. § 300(e) and 42 C.F.R. § 417.479 until they filed their motion for rehearing. Even in that motion for rehearing, petitioners emphasized that this was a case of first impression, that no federal appellate court had ever addressed the allegations made in Herdrich's complaint, and that the majority opinion "created what some might perceive as new precedent."

The arguments that petitioners now make were not properly presented below. In initially opposing Herdrich's appeal, petitioners made absolutely no arguments about any alleged conflicts with federal statutes or agency rulings concerning HMOs.

B. Due to the Procedural Posture and Incomplete Record, This Case is Not An Appropriate Vehicle to Resolve This Highly Fact-Specific Issue

Petitioners' motion for rehearing *en banc* was denied by the Court of Appeals with Justice Easterbrook filing a written dissent. Here the petition cites the dissent of Justice Easterbrook at great length. But Justice Easterbrook assumed quite a number of facts that were not in evidence. Petitioners quote Justice Easterbrook as stating that, if the Court of Appeals' decision stands, then "the principal organizational forms through which medical care is delivered today are unlawful," (Pet. 9) and that "[p]hysicians own much of the stock of HMOs organized as corporations." (Pet. 26).

Justice Easterbrook is wrong. Because respondent's fiduciary duty count was dismissed at the pleading stage, specific facts were not presented. For instance, Justice Easterbrook has no way of knowing whether the plan in question was self-insured (meaning that the risk of loss was

retained by the plan sponsor), or whether the plan was an insured plan (meaning that the risk of loss falls on the plan itself). Neither does Justice Easterbrook know whether the HMO in question here is a staff model, group model, IPA model, or direct contract model, and whether the distinction between those models was affected by the corporate structure chosen by petitioners. Likewise, no evidence was adduced concerning the issue of whether the HMO in question is federally qualified or not. Like Justice Easterbrook, here petitioners jumped to the conclusion that all HMOs are alike. Frankly, nothing could be further from the truth.

As reported by the United States General Accounting Office, GAO/HRD-94-93, *Managed Healthcare Effect on Employers' Costs Difficult to Measure* (1993):

> The term "managed care" lacks a commonly accepted definition. It has been used to characterize a wide range of health care plans that select a network of physicians and hospitals, negotiate reimbursement levels, and apply controls on the use of services. The spectrum of such plans ranges from simple preferred provider networks to more tightly structured health maintenance organizations (HMOs).

In 1990, the United States Department of Health & Human Services presented a report to Congress entitled, *Incentive Arrangements Offered by Health Maintenance Organizations and Competitive Medical Plans to Physicians,* which concluded that the results of the department's review and analysis of physician incentive plans in a sample of HMOs showed a "wide variety of incentive plans." There were differences in the types of incentive payments, the

distribution of incentives, the basis for determining the incentive payments, and the parties or entities the incentive affected. 61 Fed. Reg. 13432 (March 1996).

An HMO may be an insurance plan only, or it may consist of an insurance plan, a group of health care providers and a hospital, or some combination of these. CIGNA, for example, is an insurance plan which hires its own physicians but contracts with independent hospitals. A large combination-type HMO is Kaiser-Permanente, a company which provides insurance, hires the physicians and other care providers, and owns the clinics and hospitals where the care takes place.[1] Kaiser-Permanente doctors can order any tests, medications, medical procedures or referrals they need ***without approval from someone in the health plan***. Physicians have full authority to make health care decisions with their patients.[2] (emphasis added). Permanente physicians are devoted full time to serving only Kaiser-Permanente members . . . ***Individual physicians are compensated on a salaried basis and do not have an incentive to ration care***.[3] (emphasis added).

Here 100% of the stock of Health Alliance is owned by the Carle physicians. The stock of Humana, Inc., one of the nation's largest managed care companies, is publicly traded. In his 1998 annual report to shareholders, Humana chairman, David A. Jones, reported that Humana, Inc.'s net income for

1. *http://www.canceronline.org/009-the-ideal.html.*

2. *http://www.kaiserpermanente.org/healthplans/doctorshands.html.*

3. *http://www.kaiserpermanente.org/newsroom/structure.html.*

1998 was $213 million or $1.27 per share for Humana's more than 167 million outstanding shares of stock.[4]

The corporate structure of Kaiser-Permanente is completely different from the corporate structure of Health Alliance. The corporate structure of Humana is completely different from the corporate structure of Health Alliance. The only uniform statement that can be made about the great variety of HMOs, is that there is no uniformity. Here there is absolutely no basis for petitioners or Justice Easterbrook to conclude that the Court of Appeals' decision, which was limited to the specific facts of this case, applies to ***any*** other HMO, much less all other HMOs.

C. Court of Appeals' Decision Does Not Equate Medical Malpractice With Breach of Fiduciary Duty

As in their motion for rehearing *en banc*, petitioners argue here that mere medical malpractice is tantamount to a breach of fiduciary duty under the Court of Appeals' ruling. Petitioners are incorrect. Medical malpractice does not constitute a breach of ERISA fiduciary duties merely because the defendant doctor is part of an HMO. In fact, here the medical malpractice portion of respondent's suit is not even before this Court. As determined by the magistrate in his ruling on petitioners' motion to dismiss amended Count III, "defendants' move to dismiss arguing that Count 3 fails to state a claim under ERISA, and that the new claim is totally unrelated to the original claim for medical negligence." (Pet. App. 62a). After successfully arguing at the trial court level that amended Count III should be dismissed due, in part, to the fact that it is totally unrelated to the remaining malpractice counts, petitioners cannot be permitted to argue

4. *http://www.humana.com/investor/1998annual/letter.html.*

that the Court of Appeals' opinion somehow "blurs" the distinction between traditional medical malpractice and breach of fiduciary duties under ERISA.

II.

COURT OF APPEALS' DECISION DOES NOT CONFLICT WITH THE DECISIONS OF THIS COURT, NOR WITH THE DECISIONS OF OTHER COURTS.

A. Court of Appeals' Decision Complements, Rather Than Abrogates, Legislation Enabling Health Maintenance Organizations

Citing 42 U.S.C. § 300(e) and 42 C.F.R. § 417.479, petitioners state that the Court of Appeals decision effectively bypasses express congressional authorization of HMOs. (Pet. 10, 17). This is incorrect. 42 U.S.C. § 300(e) is merely enabling legislation. Respondent here does not dispute that HMOs are legally authorized. But the issue is not whether HMOs are legally authorized, nor whether cost-containment incentives in general are permissible. The issue presented here is whether this particular corporate structure and cost-containment incentive scheme violate ERISA.

Petitioners are correct in stating that 42 C.F.R. § 417.479 addresses the issue of cost-containment incentives for HMOs receiving Medicare or Medicaid payments. But as stated above, because Count III was dismissed at the pleading stage, no evidence was presented as to whether Health Alliance was federally qualified and participating in Medicare and Medicaid. As a consequence, there is no evidence as to whether 42 C.F.R. § 417.479 even applies to Health Alliance. But more importantly, there is no conflict between the

decision of the Court of Appeals and 42 C.F.R. § 417.479, which was promulgated by the United States Department of Health & Human Services' Health Care Financing Administration. Both the Court of Appeals and H.C.F.A. recognized and were sensitive to the problems inherent in a cost-containment incentive scheme. In order to qualify for Medicare or Medicaid payments, an HMO's contract with H.C.F.A. must specify that the HMO may operate a physician incentive plan ***only*** if no specific payment is made directly or indirectly under the Plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee, and only if further disclosure requirements of H.C.F.A. are met. In point of fact, the rules and regulations adopted by H.C.F.A. attempt to address the very issues addressed by the Court of Appeals in its decision. The H.C.F.A. rules and regulations are perfectly consistent with the ruling of the Court of Appeals.

B. Petitioners are Clearly Fiduciaries Under ERISA

Petitioners suggest that the Court of Appeals decision is inconsistent with this Court's decisions in *Hughes Aircraft Co. v. Jacobson*, __ U.S. __, 119 S. Ct. 755 (1999) and *Lockheed Corp. v. Spink*, 517 U.S. 882, 116 S. Ct. 1783 (1996). But neither the *Hughes Aircraft* case nor the *Lockheed* case is applicable to the case at bar. *Hughes Aircraft* involved the amendment of a pension plan and did not involve fiduciary duties concerning administration of the Plan's assets. In *Hughes Aircraft*, this Court was quick to point out that ERISA provides an employer with broad authority to amend a benefit plan, and that, given the employer's obligation to make up any shortfall, no member of a defined benefit plan under ERISA has a claim to any particular asset that composes a part of the Plan's general asset pool.

Like *Hughes Aircraft*, the *Lockheed* case involved a lawsuit against the employer-sponsor of a pension plan. The case at bar does not involve a pension plan, and the plan sponsor, State Farm Insurance, is not even a party to this lawsuit. But more importantly, this Court's ruling in *Lockheed* (plan sponsors who alter the terms of a plan do not fall into the category of fiduciaries) is completely irrelevant where, as here, petitioners have declared themselves to be ERISA fiduciaries and have obtained beneficial rulings based up on that status.

Moreover, the ruling of the Court of Appeals is consistent with a number of other federal court decisions that specifically address HMOs and healthcare plans as opposed to pensions. In *Biomet v. Black*, __ F. Supp. 2d __, (N.D. Ind. 1999), the Biomet Health Benefit Plan filed a complaint against one of its participants to enforce a subrogation lien for medical payments of $91,006.02 made for injuries sustained in a motor vehicle accident. The employee-participant sought dismissal of the complaint on the basis that the Health Benefit Plan was not a "participant, beneficiary or fiduciary" under § 501(a)(3). The District Court disagreed, holding that the Health Benefit Plan was a fiduciary, relying in part on *Health Cost Controls v. Bichanich*, 968 F. Supp. 396 (N.D. Ill. 1997). In *Bichanich*, the Plan itself was not seeking to enforce its subrogation rights. Rather, a collection agency, Health Cost Controls, was seeking to recover on behalf of the Plan. The Court for the Northern District of Illinois specifically ruled that, by definition, an asset is anything of value to the Plan. The ability to recover benefits previously paid out is unquestionably valuable to the Plan; that Health Cost Controls exercised substantial discretion over these plan assets and was, therefore, a fiduciary under ERISA. *See also*

O'Reilly v. Ceuleers, 912 F.2d 1383 (11th Cir. 1990); *Moralis v. Health Plus, Inc.*, 954 F. Supp. 464 (D.P.R. 1997) (an HMO can be an ERISA fiduciary when it exercises discretionary authority or discretionary responsibility in the administration of the healthcare plan). Petitioners do not cite a single decision of any lower court that is in conflict with the 7th Circuit's decision here. There is no reason to use this case as vehicle to resolve the issue of whether HMOs breach any fiduciary duties under ERISA by implementing cost containment incentives.

Petitioners and Justice Easterbrook accuse the Court of Appeals of "stretching" the definition of fiduciary. Even ignoring petitioner's own assertion that they are fiduciaries, it is relatively clear that neither petitioners nor Justice Easterbrook are conversant with the current state of the law on this topic.

CONCLUSION

The petition for certiorari should be denied.

Respectfully submitted,

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APPENDIX

APPENDIX A — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF ILLINOIS, PEORIA DIVISION DATED AND FILED MAY 13, 1996

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS
PEORIA DIVISION

No. 94-1143

CYNTHIA HERDRICH,

Plaintiff,

vs.

LORI PEGRAM and CARLE CLINIC ASSOCIATION, HEALTH ALLIANCE MEDICAL PLANS, INC.

Defendants.

ORDER

Before this Court is Plaintiff's Motion to Remand [#43], which the Defendants oppose. For the reasons stated herein, this Court DENIES the Motion to Remand.

Plaintiff filed a two-count complaint in State court on October 21, 1992. Count I alleged medical negligence against Defendant Lori Pegram for failing to employ the skill and care ordinarily used by a reasonably well-qualified physician resulted in a ruptured appendix, which caused peritonitis. Count II seeks to hold Carle Clinic Association ("Carle Clinic") liable under the theory of respondeat superior.

Appendix A

Herdrich filed an addendum to her State court complaint in February 1994, adding Counts III and IV. Count III alleges that Carle Clinic failed to disclose certain material facts regarding the ownership of Health Alliance Medical Plans ("Health Alliance") in violation of the Illinois Consumer Fraud Act 815 ILCS 505/1 *et seq*. Count IV charged that Health Alliance breached its duty of good faith and fair dealing.

The Defendants filed a Notice of Removal with this Court on March 14, 1994, asserting that Counts III and IV were preempted by the Employees Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1101, and that the pendant state claims set forth in Counts I and II were removable pursuant to 28 U.S.C. §1367. Herdrich filed a Motion to Remand on April 8, 1994. On July 22, 1994, Magistrate Judge Robert J. Kauffman recommended the Motion to Remand be denied. This Court adopted the Magistrate's Report and Recommendation and denied the Motion to Remand on August 5, 1994.

Thereafter, Defendants moved for summary judgment as to Counts III and IV. In an Order dated July 25, 1995, this Court granted the motion for summary judgment as to Count IV. The Order also found that ERISA preempted Count III, and that Herdrich would have to amend her complaint as Count III did not state a claim under ERISA.

Herdrich filed an Amended Count III on September 1, 1995. On November 14, 1995, Defendants filed a Motion to Dismiss Amended Count III. On March 26, 1996, Magistrate Judge Kauffman granted the Motion to Dismiss in a Report and Recommendation and granted Herdrich leave to file an

Appendix A

amended Count III. Herdrich appealed the Magistrate Judge's ruling under Federal Rule of Civil Procedure 72. This Court adopted the recommendation and granted Herdrich leave to file a second amended Count III.

Herdrich then filed her Motion to Remand. In her Motion, she states, "Plaintiff will not further amend her ERISA count (Count III), but rather chooses to stand on those pleadings." She then argues that this Court should remand the matter because this Court lacks jurisdiction to consider the underlying medical malpractice actions.

Defendants oppose the Motion to Remand and argue that this Court should retain jurisdiction under 28 U.S.C. § 1367. Counsel for the Defendants has represented that Herdrich will appeal this Court's April 15, 1996 ruling granting the Motion to Dismiss if the Motion for Remand is granted. Section 1367 provides, in relevant part:

> (a) [T]he district courts shall have supplemental jurisdiction over all other claims that are so related to claims in the action within such original jurisdiction that they form part of the same case or controversy under Article III of the United States Constitution.
>
> * * *
>
> (c) The district courts may decline to exercise supplemental jurisdiction over a claim under subsection (a) if —
>
> > (1) the claim raises a novel or complex issue of State law,

> (2) the claim substantially predominates over the claim or claims over which the district court has original jurisdiction, [or]
>
> (3) the district court has dismissed all claims over which it has original jurisdiction.

28 U.S.C. § 1367.

In the case at bar, the medical malpractice claims do not present novel or complex issues of state law. Subsection (2) does not apply to this matter as the federal claims have fallen out of the suit. Finally, this Court has dismissed all claims over which it had original jurisdiction. This litigation is over two years old and judicial economy would not be served by remanding the matter to State court. Moreover, if Herdrich decides to appeal this Court's April 15, 1996 Order, the Defendants would be fighting this battle on two fronts: in the Court of Appeals and in State court. This Court finds that both judicial economy and fairness will be served by retaining Counts I and II.

For the reasons set forth herein, this Court DENIES the Motion to Remand [#43]. This matter is referred to Magistrate Judge Kauffman.

ENTERED this 13th day of May, 1996.

s/ Michael M. Mihm
Michael M. Mihm
Chief United States District Judge

APPENDIX B — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF ILLINOIS, PEORIA DIVISION DATED AND FILED JULY 25, 1995

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS
PEORIA DIVISION

No. 94-1143

CYNTHIA HERDRICH,

Plaintiff,

vs.

LORI PEGRAM and CARLE CLINIC ASSOCIATION, HEALTH ALLIANCE MEDICAL PLANS, INC.

Defendants.

ORDER

Before the Court are Defendants' Motion for Summary Judgment [#16] and Plaintiff's Motion for Leave to File Amended Complaint [#22]. For the reasons set forth herein, the Motion for Summary Judgment is GRANTED in part and DENIED in part. The Motion for Leave to File Amended Complaint is GRANTED in part and DENIED in part.

Factual Background

Plaintiff filed a two count complaint in State court on October 21, 1992. Count I alleged medical negligence against

Defendant Lori Pegram ("Pegram") for failing to adequately examine, treat, and follow-up on Plaintiff's complaint of right, lower quadrant pain. She claims that Pegram's failure to employ the skill and care ordinarily used by a reasonably well-qualified physician resulted in a ruptured appendix, which caused peritonitis. Count II seeks to hold Carle Clinic Association ("Carle Clinic") liable under the theory of respondeat superior. Defendants Pegram and Carle Clinic filed an Answer to the State court complaint on December 8, 1992.

Herdrich filed an addendum to her State court complaint in February 1994, adding Counts III and IV. Count III alleges that Carle Clinic failed to disclose certain material facts regarding the ownership of Health Alliance Medical Plans ("Health Alliance") in violation of the Illinois Consumer Fraud Act 815 ILCS 505/1 et seq. Count IV charges Health Alliance breached its duty of good faith and fair dealing. All of the Defendants filed a Notice of Removal with this Court on March 14, 1994, asserting that Counts III and IV were preempted by the Employees Retirement Income Security Act ("ERISA"), 29 U.S.C. §1101, and that the pendant state claims set forth in Counts I and II were removable pursuant to 28 U.S.C. §1367. Herdrich filed a Motion to Remand on April 8, 1994.

Her Motion to Remand argued that ERISA did not preempt Counts III and IV of her State court complaint because the State laws at issue did not relate to an employee benefit plan. Plaintiff asserted that Counts III and IV were merely related to employee benefits generally. ERISA's preemption provision provides, in relevant part,

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State law insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title . . .

29 U.S.C. § 1144(a). She maintained that State law actions which are merely incidentally connected to an employee welfare benefit plan are not preempted by ERISA, citing *Mackey v. Lanier Collections Agency & Service*, 486 U.S. 825, 108 S.Ct. 2182 (1988). She concluded that Counts III and IV of her Complaint only indirectly affected the administration of a plan, in that her claims arose out Defendants' business decisions and therefore were not preempted.

In opposition to the Motion to Remand, Defendants argued that Counts III and IV related to the administration of a plan and were thus preempted under ERISA. Specifically, Defendants set forth a Synopsis of Relevant Facts which stated that Herdrich was a participant and beneficiary in an employee benefit plan ("the Plan") provided to her through her husband's employer, State Farm Insurance Companies. The factual synopsis also asserted that Defendant Health Alliance was the administrator and fiduciary of the Plan. Finally, Defendants contended that as part of the Plan, Health Alliance contracted with Carle Clinic to provide medical care to Plan participants in accordance with an agreed upon fee schedule. In response to Herdrich's legal argument that Count IV was not preempted because it lacked the necessary relationship to an employee benefit plan,

Defendants maintained that plaintiff's reference to the Plan and Health Alliance's duty in her Addendum to the Complaint evidenced a relation between Count IV and the employee welfare benefit plan.

On July 22, 1994, Magistrate Judge Robert J. Kauffman recommended the Motion to Remand be denied. (Report and Recommendation, at 1). The Magistrate Judge found that Count IV related to an employee welfare benefit plan, and as such, was preempted by ERISA. *Id.* at 2-3. The Magistrate did not find specifically that Count III was preempted. Neither party filed objections to the Magistrate's Report and Recommendation, and this Court adopted the Magistrate's Report and Recommendation, denying the Motion to Remand on August 5, 1994.

Discussion

A motion for summary judgment will be granted where there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Fed.R.Civ.P. 56(c). The moving party has the responsibility of informing the court of portions of the record or affidavits that demonstrate the absence of a triable issue. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323, 106 S.Ct. 2548, 2552 (1986). The moving party may meet its burden of showing an absence of material facts by demonstrating "that there is an absence of evidence to support the non-moving party's case." *Id.*, at 325, 106 S.Ct. at 2553. Any doubt as to the existence of a genuine issue for trial is resolved against the moving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255, 106 S.Ct. 2505, 2513 (1986); *Cain v. Lane*, 857 F.2d 1139, 1142 (7th Cir. 1988).

If the moving party meets its burden, the non-moving party then has the burden of presenting specific facts to show that there is a genuine issue of material fact. *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 586-87, 106 S.Ct. 1348, 1355-56 (1986). Federal Rule of Civil Procedure 56(e) requires the non-moving party to go beyond the pleadings and produce evidence of a genuine issue for trial. *Celotex Corp.*, 477 U.S. at 324, 106 S.Ct. at 2553. This Court must then determine whether there is a need for trial — whether, in other words, there are any genuine factual issues that properly can be resolved only by a finder of fact because they may be reasonably resolved in favor of either party. *Anderson*, 477 U.S. at 250, 106 S.Ct. at 2511.

Defendants submit that the Plan, through a subscription issued by Carle Clinic Health Maintenance Organization (Carle HMO), provided health and medical benefits to its participants and qualifies as an ERISA plan pursuant to 29 U.S.C. §1001 *et seq*. Defendants assert that Plaintiff's contract with Health Alliance resulted solely from her enrollment in the Plan. Defendants contend, and Plaintiff does not deny, that all benefits provided for under the Plan were paid. Defendants state, without reference to supporting material, that Carle HMO acts as the fiduciary of the Plan. However, the Defendants also frame the issues contained in the Motion for Summary Judgment as "whether an ERISA plan participant/beneficiary may sue an ERISA plan fiduciary under Illinois common law and under the Illinois Consumer Fraud Act, 815 ILCS 505/1, *et seq*., to recover extra-contractual damages," indicating that Carle Clinic and Health Alliance function as fiduciaries. This statement, taken in conjunction with the prior representations made by

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Defendants, indicates that there are three fiduciaries of the Plan: Carle Clinic, Health Alliance, and Carle HMO. Defendants' primary argument in support of its Motion for Summary Judgment, as to Count IV, is that regardless of who functions as the fiduciary, Plaintiff is not entitled to extracontractual damages under ERISA.

Herdrich claims that the Motion for Summary Judgment is "vague and ambiguous." She contends that Carle HMO is a product, not an entity and as such cannot qualify as a fiduciary under 29 U.S.C. §1002(21)(A). She also submits that Carle Clinic is not a fiduciary as a matter of law and Defendants have failed to present evidence which supports their assertion that Carle Clinic is a fiduciary. Further, she argues that Health Alliance does not appear to be a fiduciary of the Plan as a matter of fact. In support of this contention, Herdrich cites to Health Alliance's 1992 Annual Statement, filed with the Illinois Department of Insurance, which states that Health Alliance is not a "provider of administrative services or 'stop loss' group accident and health insurance to a multiple employer trust or multiple employer welfare arrangement." Herdrich submits that Carle Health Insurance Management Company ("CHIMCO") is, in fact, the fiduciary of the Plan. This Court will first address the issues raised by the parties in terms of Count IV, as neither the Magistrate Judge nor this Court have determined that Count III is preempted by ERISA. Then this Court will determine, for purposes of jurisdiction, whether Count III is preempted by ERISA.

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A. Count IV

As there are serious questions about which organization(s) function as the fiduciary, this Court must determine whether this Plaintiff can recover the type of damages she seeks in Count IV, regardless of who exists as the fiduciary. Herdrich submits that ERISA provides for extracontractual damages in §502(a)(3). Plaintiff cites *Blue Cross and Blue Shield of Alabama v. Lewis*, 753 F.Supp. 345, 347 (N.D.Ala. 1990), for the proposition that §502(a) of ERISA allows for extracontractual, even punitive damages. Herdrich concedes, however, that the Seventh Circuit does not follow the holding in *Lewis*, stating that "[i]t is doubtful that the Seventh Circuit's refusal to follow the ruling of the Alabama District Court is justified since the Seventh Circuit apparently ignored the intent of Congress." (Mem. in Opposition to Summary Judgment, at 4).

Defendants cite the Supreme Court's holding in *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 105 S.Ct. 3085 (1985), for the proposition that ERISA prohibits the award of extracontractual damages. ERISA's civil enforcement provision, § 502(a) provides, in relevant part,

> A civil action may be brought —
>
> (1) by a participant or beneficiary — (A) for the relief provided for in subsection (c) of this section, or (B) to recover benefits due to him under the

terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of his plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

29 U.S.C. § 1132(a). Section 409, entitled Liability for breach of fiduciary duty states, in part,

> (a) Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other

> equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

29 U.S.C. § 1109(a).

In *Russell*, the plaintiff received benefits under an employee welfare benefit plan for a back injury from May 1979 until October 17, 1979 when an orthopedic surgeon reported that the plaintiff was no longer disabled. *Russell*, 473 U.S. at 136. The plaintiff requested a review of the termination of her benefits and proffered a report from her psychiatrist ". . . indicating that she suffered from a psychosomatic disability with physical manifestations rather than an orthopedic illness." *Id.* When this report was confirmed by a second psychiatrist, the plan administrator reinstated plaintiff's benefits — including a retroactive payment. *Id.* The plaintiff's suit, brought under §502(a)(2), alleged that she sustained an injury "by the improper refusal to pay benefits from October 17, 1979, when her benefits were terminated, to March 11, 1980, when her eligibility was restored." *Id.*

The Court granted certiorari "to review both the compensatory and punitive components of the Court of Appeals holding that § 409 authorizes recovery of extracontractual damages." *Id.* at 138. The Court held that § 502(a)(2) authorizes a plan beneficiary to bring suit against a fiduciary under § 409. Any recovery for a breach of fiduciary duty, however, "inures to the benefit of the plan as a whole." *Id.* at 140. Further, the Court's decision states that within the context of §§ 502(a)(2) and 409, "we do not find in §409 express authority for an award of extracontractual

damages to a beneficiary." *Id.* at 144. The Court did not address whether a plan could recover extracontractual damages from a fiduciary under § 409. *Id.* at n.12.

The Court noted that because the plaintiff relied "... entirely on §409(a), and expressly disclaimed reliance on §502(a)(3), we have no occasion to consider whether any other provision of ERISA authorizes recovery of extra-contractual damages." *Id.* at 139, n.5. Therefore, regardless of the identity of the fiduciary, to the extent that Plaintiff seeks recovery of extracontractual damages under §§ 502(a)(2) and 409(a), summary judgment is granted in favor of the Defendants.

The plaintiff in *Russell* also argued that a private right of action for extracontractual damages should be implied absent an express authorization by ERISA. *Russell*, 473 U.S. at 145. The Court looked to the four-factor test employed by *Cort v. Ash*, 422 U.S. 66, 78 (1975), to determine whether an implied right of action for extracontractual damages exists under ERISA. *Id.* at 145. The Court declined to extend the *Ash* decision to "authorize the recovery of extracontractual damages. Because 'neither the statute nor the legislative history reveals a congressional intent to create a private right of action.' " *Id.* at 148 (quoting *Northwest Airlines, Inc. v. Transport Workers*, 451 U.S. 77, 94, n.31 (1981)). To the extent. Herdrich argues for an implied right of action for extracontractual damages, the *Russell* case controls. No such right exists.

As the *Russell* decision left open the issue of whether §502(a)(3) would permit recovery of extra-contractual

damages, this Court must now turn to Plaintiff's argument that after the Supreme Court's decision in *Ingersoll-Rand Co. v. McClendon*, 111 S.Ct. 478 (1990). 502(a)(3) should be found to allow for the recovery of extracontractual damages by a plan beneficiary. In *Harsch v. Eisenberg*, 956 F.2d 651 (7th Cir.), *cert. denied,* 113 S.Ct. 61 (1992) the plaintiffs filed a suit against their employer, a law firm, and the employee welfare benefit plan to which they belonged. *Harsch*, 956 F.2d at 652-53. The plaintiffs alleged that their employer "had refused to comply with the plaintiffs' written request for information and claims for benefits, in violation of the terms of the plan, the policy and practices of the firm, and ERISA" and sought compensatory and punitive damages. *Id.* at 653. In holding that neither §502(a)(1)(B) nor §502(a)(3)(B) provided for compensatory damages, the *Harsch* court discussed the impact of *McClendon* on the *Russell* holding. *Id.* at 655, 659-660. The Seventh Circuit focused on the last paragraph of the *McClendon* opinion which states:

> [T]here is no basis in § 502(a)'s language for limiting ERISA actions to only those which seek "pension benefits." It is clear that the relief requested here is well within the power of the federal courts to provide. Consequently, it is no answer to a preemption argument that a particular plaintiff is not seeking the recovery of pension benefits.

Id. at 659 (quoting *McClendon*, 111 S.Ct. at 486). After summarizing the post-McClendon case law, including *Blue Cross and Blue Shield v. Lewis, supra,* the case our Plaintiff

relies upon, and *International Union, United Automobile, Aerospace and Agricultural Implement Workers v. Midland Steel Products Co.*, 771 F.Supp. 860, 863 (N.D.Ohio 1991), the Seventh Circuit concluded that the dicta from *McClendon* did not authorize the recovery of compensatory damages under §502(a)(3). *Id.* at 660 ("we are not rash enough to believe that the Court intended to overrule settled law in most of the circuits, as well as narrowly limit — if not overrule — its own decision in *Russell* in such an off-hand manner").

As to the availability of punitive damages under either §502(a)(1)(B) or §502(a)(3), the *Harsch* court found neither section of ERISA allowed for punitive damages. *Id.* at 661 Specifically as to §502(a)(3), the court cited its prior holding in *Kleinhans v. Lisle Savings Profit Sharing Trust*, 810 F.2d 618, 627 (7th Cir. 1987) (punitive damages are not available under § 502(a)(3)). Other courts have relied upon *Harsch* in finding that § 502(a)(3) does not provide for extracontractual damages. *See e.g. Lafov v. HMO Colorado*, 988 F.2d 97, 99 (10th Cir. 1993); *Medina v. Anthem Life Ins. Co.*, 983 F.2d 29, 32 (5th Cir. 1993); *Zimmerman v. Sloss Equipment, Inc.*, 835 F.Supp. 1283, 1291 (D.Kan. 1993); *Pension Plan of Public Service Assoc. of New Hampshire et al. v. KPMG Peat Marwick*, 815 F.Supp. 52, 56-57, n.2 (D.N.H. 1993). Although Herdrich suggests that the Seventh Circuit's decision in *Harsch* is an incorrect reading of *Russell* and *McClendon*, this Court chooses to follow the Seventh Circuit's well reasoned holding.

Additionally, the Supreme Court has recently elaborated on the reference in § 502(a)(3)(B) to "other appropriate

equitable relief." *Mertens v. Hewitt Assoc.*, 113 S.Ct. 2063 (1993). The Court granted certiorari to answer the question ". . . whether ERISA authorizes suits for money damages against non-fiduciaries who knowingly participate in a fiduciary's breach of fiduciary duty." *Id.* at 2066. In determining that a beneficiary may not recovery monetary damages from a non-fiduciary, the Court held that §502(a)(3)(B) included typical remedies available in equity and not "legal remedies" like compensatory damages or monetary relief. *Id.* at 2069. The *Mertens* decision was limited to the type of damages which may be recovered under § 502(a)(3). *Anweiler v. American Elec. Power Service Corp.*, 3 F.3d 986, 993 (7th Cir. 1993). Thus, *Mertens* gives further support to this Court's conclusion that to the extent Herdrich relies on §502(a)(3)(B) as a basis for monetary relief, as opposed to equitable relief, she may not proceed as a matter of law. This Court finds that plaintiff's claim for extracontractual damages against Defendant Health Alliance may not, as a matter of law, survive summary judgment. As this Court's finding is not specific to Health Alliance, but may be applied to any fiduciary, Plaintiff's Motion for Leave to Amend is denied as to Count IV.

B. Count III

As the Magistrate Judge left open the question of whether Count III of Plaintiff's Complaint is preempted, this Court must determine, as a jurisdictional matter, whether Count III is preempted by ERISA. If not, the matter should be remanded to State court. As set forth above, Count III alleges that Carle Clinic failed to disclose certain material facts regarding the ownership of Health Alliance in violation of

the Illinois Consumer Fraud Act 815 ILCS 505/1 *et seq.* Specifically, Plaintiff claims that Carle Clinic sold her a subscription in Carle HMO through its wholly owned subsidiary Health Alliance. Plaintiff maintains that Defendant Carle Clinic violated the Consumer Fraud act by failing to advise her that the Carle HMO physicians hired by Health Alliance, in fact owned Health Alliance. Plaintiff also avers that Defendant Carle Clinic failed to inform her that the compensation of Carle HMO physicians was "increased to the extent that those physicians did not order diagnostic tests; did not utilize facilities not owned by those physicians; and did not make emergency or consultation referrals." (Addendum to Complaint, at 2). Count III seeks an amount in excess of $15,000.00 plus costs and attorney fees.

In ERISA's §1, Congress articulated its declaration of policy, stating: ". . . to provide for the general welfare and free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans." 29 U.S.C. § 1001(a). In ERISA, Congress set out to

> protect . . . participants in employee benefit plans . . . by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions and ready access to the Federal courts.

29 U.S.C. § 1001(b). Herdrich's claim in Count III is essentially that Defendants failed to disclose relevant, material information regarding the operation of the Plan. In order to find Count III preempted by ERISA, the State law which forms the basis of the claim must "relate to" an employee welfare benefit plan. 29 U.S.C. § 1144(a). The Supreme Court has given a broad interpretation to the "relate[s] to" requirement. In *Shaw v. Delta Air Lines*, 463 U.S. 85, 97, 103 S.Ct. 2890, 2900 (1983), the Court held that "a law 'relates to' an employee benefit plan in the normal sense of the phrase, if it has a connection with or reference to such plan." *Shaw*, 463 U.S. at 97.

ERISA contains detailed disclosure requirements. In § 101, the statute requires the administrator of each employee benefit plan to provide all participants with a summary plan description and fiscal statements and schedules. 29 U.S.C. § 1021(a) The summary plan description must include the following:

> The name and type of administration of the plan, the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator, names, titles, and addresses of any trustee or trustees (if they are persons different from the administrator); a description of the relevant provisions of an applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension

> benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of he end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part.

29 U.S.C. § 1022(b). Additionally, ERISA requires each employee benefit plan publish an annual report, which is to be filed with the Secretary and made available to the plan participants and beneficiaries. 29 U.S.C. §§ 1023(a)(1)(A) and 1024(a) & (b) The annual report must contain a financial statement and opinion. 29 U.S.C. § 1023(a)(1)(B)(i). The financial opinion must issue from an independent qualified public accountant. 29 U.S.C. § 1023(a)(3)(A). The financial statement must include "a statement of assets and liabilities; a statement of changes in fund balance; and a statement of changes in financial position." 29 U.S.C. § 1023(b)(1). The notes accompanying the financial statement must contain the following disclosures:

> [A] description of the plan including any significant changes in the plan made during the period and the impact of such changes on benefits; a description of material lease commitments, other commitments, and contingent liabilities; a description of agreements and transactions with

> person known to be parties in interest; a general description of priorities upon termination of the plan; information concerning whether or not a tax ruling or determination letter has been obtained; and any other matters necessary to fully and fairly present the financial statements of the plan.

29 U.S.C. § 1023(b)(1). ERISA also dictates the schedules which must be attached to the financial statements. 29 U.S.C. §1023(b)(3). The annual report must also contain an actuarial statement and opinion prepared by an enrolled actuary. 29 U.S.C. § 1023(a)(4)(A)

It is apparent from this brief review of ERISA's disclosure requirements that the statute comprehensively regulates the necessary disclosures. Count III seeks to impose additional disclosure requirements on the plan administrator other than those which are expressly enumerated in ERISA. This Court finds that under the broad reach of ERISA's § 514, Plaintiff's Count III relates to an employee benefit plan, and as such is preempted.

Having found Count III preempted, Herdrich must now allege which of ERISA's civil enforcement provisions, if any, would be provide a cause of action for Plaintiff. The availability of a federal remedy does not govern the preemption decision, and thus it may be that Plaintiff has no cause of action under ERISA. *Lister v. Stark*, 890 F.2d 941, 946 (7th Cir. 1989). Plaintiff is given leave to submit an amended Count III which clearly sets forth her basis for proceeding under ERISA, including the applicable civil enforcement provision. If Plaintiff declines this opportunity,

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Count III will be dismissed with prejudice, and the remaining matters will be remanded to State Court.

Conclusion

For the reasons stated herein, the Motion for Summary Judgment as to Count IV is GRANTED in favor of Defendant Health Alliance Medical Plans, Inc. with costs. The Motion for Summary Judgment as to Count III is DENIED. The Plaintiff has fourteen (14) days to file her amended Complaint as to Count III, specifying under which of ERISA's civil enforcement provisions she intends to proceed. IT IS SO ORDERED.

ENTERED this 25th day of July, 1995.

s/ Michael M. Mihm
Michael M. Mihm
Chief United States District Judge

APPENDIX C — MEMORANDUM IN OPPOSITION TO PLAINTIFF'S MOTION TO REMAND

IN THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF ILLINOIS PEORIA DIVISION

No. 94-1143

CYNTHIA HERDRICH,

Plaintiff,

vs.

LORI PEGRAM and CARLE CLINIC ASSOCIATION, HEALTH ALLIANCE MEDICAL PLANS, INC.

Defendants.

MEMORANDUM IN OPPOSITION TO PLAINTIFF'S MOTION TO REMAND

Introduction

Defendants, Lori Pegram, M.D., Carle Clinic Association, and Health Alliance Medical Plans, Inc., removed this case on March 14, 1994. The state trial court in the Eleventh Circuit of Illinois, McLean County, had allowed the plaintiff to amend her pleadings on February 18, 1994. The new allegations, Counts III and IV, for the first time, raise claims which relate to an employment benefit plan, as defined and preempted by Section 514(a) of ERISA (29 U.S.C. Section 1144(a)(1988)). The original complaint,

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Counts I and II failed to adequately set forth a claim or right arising under the Constitution, treatises or laws of the United States, in that they stated a claim for professional negligence against Lori Pegram, M.D. (Count I) and *respondeat superior* against Carle Clinic Association (Count II).

After receipt of plaintiff's Addendum to the Complaint as stated above, the defendants were, for the first time, put on notice that the plaintiff was asserting an action which was removable to this Court since the Addendum, for the first time, brought a claim over which this Court has original jurisdiction of the provisions of Title 28, U.S.C., Section 1441(b) and Title 29, U.S.C., Section 1144(a). Removal of this matter was, therefore, timely. Plaintiff has not raised timeliness as an objection to the removal.

Rather, plaintiff asserts in the motion to remand and supporting memorandum, that the claims set forth in Counts III and IV of the Addendum to the complaint do not "relate to" any employee benefit plan . . . as set forth in Section 514(a) of ERISA.

Synopsis of Relevant Facts

The plaintiff, Cynthia Herdrich, was a participant and beneficiary in an employee benefit plan ("the Plan") provided to her by her husband's employer, State Farm Insurance Companies. Defendant, Health Alliance Medical Plans, Inc. ("Health Alliance") was the administrator and fiduciary of the Plan within the meaning of ERISA (29 U.S.C. Section 1001 et seq.)

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As part of the Plan, Health Alliance entered into a contract with Carle Clinic Association ("Carle") in which Carle agreed to provide medical care to participants in the Plan in accordance with an agreed upon fee schedule. Defendant, Dr. Lori Pegram, is an employee of the Carle Clinic Association. In March of 1991, Cynthia Herdrich has alleged she was suffering from right, lower quadrant pain resulting from appendicitis. She was seen by Dr. Pegram on March 1, 1991. On March 7, 1991, plaintiff's appendix perforated. On March 15, 1991, plaintiff underwent a successful exploratory laparotomy.

This action was commenced in state court on October 21, 1992. The original action was for the alleged malpractice of Dr. Pegram and under a theory of *respondeat superior,* Carle Clinic Association. Initially they were the only defendants.

In February of 1994, the plaintiff was allowed leave to file an Addendum to the Complaint, which for the first time, added Health Alliance Medical Plans, Inc. as an additional defendant. For the first time, plaintiff alleged that Carle Clinic, P.C., violated the Illinois Consumer Fraud Act (815 ILCS 505/1 et seq.) by allegedly failing to advise the plaintiff that the Carle Care HMO physicians hired by Health Alliance in fact owned Health Alliance and failed to advise plaintiff that the compensation of the Carle Care HMO physicians hired by Health Alliance was increased to the extent that those physicians did not order diagnostic tests; did not utilize facilities not owned by those physicians; and did not make emergency or consultation referrals. It was further alleged, for the first time, that Health Alliance breached a duty of

good faith and fair dealing in arranging medical and hospital services by having its contracted physicians minimize the use of diagnostic tests, the facilities not owned by those physicians, and the emergency consultation referrals.

Federal Preemption

The United States Constitution provides that "The Laws of the United States . . . shall be the supreme Law of the Land . . . anything in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const. art. VI, cl. 2. Thus, since *McCulloch v. Maryland,* 17 U.S. 316, 427 (1819) (Wheat.), state law that conflicts with federal law has no effect. *Maryland v. Louisiana,* 451 U.S. 725, 746 (1981). However, Supremacy Clause analysis "start[s] with the assumption that the historic police powers of the states [are] not to be superseded by Federal Act *unless that [is] the clear and manifest purpose of Congress*". *Rice v. Santa Fe Elevator Corporation,* 331 U.S. 218, 230 (1947) (emphasis added). Accordingly, the purpose of Congress is the "ultimate touchstone" of preemption analysis. *Malone v. White Motor Corporation,* 435 U.S. 497, 504 (1978) (quoting *Retail Clerks v. Schermerhorn,* 375 U.S. 96, 103 (1963)).

Congress' purpose may be stated explicitly in a statute's language or contained implicitly in the statute's structure and purpose. *Jones v. Rath Packing Co.,* 430 U.S. 519, 525 (1977). For example, state law is preempted if it actually conflicts with federal law, even in the absence of an express Congressional command. *Pacific Gas & Electric Co. v. Energy Resources Conversation and Dev. Comm'n.,* 461 U.S. 190, 204 (1983). State law also is preempted if federal law

"so thoroughly occupies a legislative field as to make reasonable the inference that Congress left no room for the states to supplement it." *Fidelity Federal Savings & Loan Association v. De la Cuesta,* 458 U.S. 141, 153 (1982). Both of these principles of preemption apply in the case of ERISA.

ERISA Preemption

Section 514(a) of ERISA provides, in part:

> [T]he provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in Section 1003(a) of this Title and not exempt under Section 1003(b) of this Title. 29 U.S.C. Section 1144(a)(1988)

The United States Supreme Court, commenting upon the breadth of this provision, described it as a "virtually unique preemption provision." *Franchise Tax Board v. Construction Laborers Vacation Trust,* 463 U.S. 1, 24 n.26 (1983) Congress' purpose in enacting ERISA is the "ultimate touchstone" in determining ERISA preemption. *Pilot Life Insurance Co. v. Dedeaux,* 481 U.S. 41, 45 (1987). Congress enacted ERISA to protect employees' anticipated benefits. 29 U.S.C. Section 1001(1988). ERISA's preemption clause protects employee benefit plans from conflicting and inconsistent state laws because such laws may hinder a plan's ability to administer benefits uniformly. *Fort Halifax Packing Co. v. Coyne,* 428 U.S. 1, 8-9 (1987).

Appendix C

There are a number of Supreme Court decisions interpreting ERISA's preemption clause. One of the earliest to find preemption is *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981). In *Alessi*, the court included that ERISA preempts a New Jersey statute prohibiting an offset against employee retirement benefits for the amount a retiree received in workers' compensation. In so finding, the court concluded that the New Jersey statute "relates to" pension plans governed by ERISA because it purports to eliminate one method of calculating pension benefits-integration that ERISA permits. The court rejected the suggestion, similarly put forth by the plaintiff here, that New Jersey law intrudes on ERISA only indirectly, through a workers' compensation law, rather than directly, through a "pension regulation." The Court observed:

> ERISA makes clear that even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern. For the purposes of the pre-emption provision, ERISA defines the term 'State' to include: 'a State, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, *directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter*.' 29 U.S.C. Section 1144(c)(2) (emphasis added).

ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the preemption provision. *Id.* at 525.

Appendix C

One of the more oft-cited Supreme Court cases on the issue of ERISA preemption is *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987). The *Pilot Life* decision is particularly interesting because it concludes that ERISA preempts certain state common-law tort and contract actions that assert improper processing of a claim under an employee benefit plan. *Pilot Life* demonstrates the expansiveness of the meaning of "State law" in Section 514(a) of ERISA, which Congress defined to include "all laws, decisions, rules, regulations, or other State action having the effect of law, of any state." 29 U.S.C. Section 1144(c)(1)(1988).

The Court found in *Pilot Life* there was no dispute that the common-law causes of action in question — tortious breach of contract, breach of fiduciary duties, and fraud in the inducement — "related to" an employee benefit plan. Having reached this conclusion, the Court's only task was to determine whether any of the exemptions to preemption applied. The plaintiff asserted that Mississippi's law of bad faith is a law "which regulates insurance" and thus is saved from preemption by ERISA, Section 514(b)(2)(A), 481 U.S. at 47. The Court rejected this argument, however, noting that Mississippi's bad faith law, while identified with the insurance industry, has its roots in the general principles of Mississippi tort and contract law.

Of particular import to the plaintiff's Addendum to the Complaint here, in which bad faith and fraud are alleged, and the ERISA preemption of same is the discussion of preemption of such claims in *Pilot Life*:

> The policy choices reflected in the inclusion of certain remedies and the exclusion of others under

the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. The six carefully integrated civil enforcement provisions found in Section 502(a) of the statute as finally enacted . . . provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.

The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of the policies embodied in its choice of remedies argues strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive. 481 U.S. at 54.

Here, plaintiff's claim of fraud and breach of duty to act in good faith are clearly related to the employment benefit plan. To be sure, plaintiff attaches the subscription agreement to the complaint referencing same in her complaint. The plaintiff states in her Motion for Remand, "ERISA preemption is not triggered by actions which indirectly affect the administration of a benefit plan, but only those that impact directly on primary administrative functions of the plan." It is contended that the allegation of good faith and fair dealing does not "impact on" the employee benefit plan. For this proposition, the plaintiff cites the District Court for the Eastern District of Pennsylvania (*Independence HMO, Inc. v. Smith,* 733 F.Supp. 983 (E.D. Pa. 1990)). In essence, plaintiff argues that her claims are not clearly preempted

under Section 514 (29 U.S.C. Section 1144(a)(1988)) because they do not "relate to" an ERISA plan, a pre-condition to preemption under Section 514. The plaintiff's contention must fail, given the breadth placed upon the term "relates to" by the United States Supreme Court. The United States Supreme Court has stated they have no hesitation to enforce ERISA's preemption provisions where a state law creates the prospect that employer's administrative scheme would be subject to conflicting requirements. *Fort Halifax Packing Co., Inc. v. Coyne,* 42 U.S. 1.

In *First National Life Ins. v. Sunshine-Junior Food Stores,* 960 F. 2d 1546 (11th Cir. 1992) the court held:

> Moreover, state contract and tort laws that impose varying standards upon the administrator of a welfare benefit plan create a significant potential for conflict with ERISA and thus are logically preempted. As we noted earlier, Congress deliberately wrote Section 1144(a) in a broad manner in order to make pension plan regulation exclusively a federal concern. *960 F. 2d at 1550.*

In this case, as is evidenced by the fact that plaintiff, in her Addendum to the Complaint, has specifically referred to the Plan, and must in order to create any relationship or "duty" between Health Alliance and Cynthia Herdrich, the existence of the Plan is a prerequisite to the plaintiff's state law claims. In other words, absent the existence of the Plan, plaintiff would have absolutely no standing to assert any claim against Health Alliance.

Appendix C

The United States Supreme Court of Appeals for the Eleventh Circuit has similarly held in *Sanson v. General Motors Corp.*, 966 F. 2d 618 (11th Cir. 1992) that when a plaintiff would not have a state law cause of action absent the existence of an ERISA plan, the state law claim is preempted. Clearly, plaintiff's Addendum to the Complaint is based solely and completely upon her contractual relationship to the ERISA plan of Health Alliance. Thus, under the compelling rationale of *Sanson* and *First National Life Insurance* and countless other cases, plaintiff's claims here are preempted.

The plaintiff's reliance on a decision from the Eastern District of Pennsylvania is misplaced. The Pennsylvania Court has, in other decisions, found no preemption. Yet, the underpinning and rationale of those decisions has been specifically rejected by the Seventh Circuit in *Lister v. Stark*, 890 F. 2d 941 (7th Cir. 1989) *cert. den'd.* 111 S. Ct. 579 (1990) and their reasoning rejected again in *Bartholet v. Reishauer A.G. (Zurich)*, 953 F. 2d 1073, 1076-77 (7th Cir. 1992). *See, also, Christopher v. Mobil Oil Corp.*, 950 F. 2d 1209 (5th Cir. 1992); *Bernatowicz v. Colgate Palmolive Co.*, 1992 U.S. Dist. Lexis 2889 (D. N.J. 1992). Not a single federal court has followed or adopted the line of cases from the Eastern District of Pennsylvania. Indeed, every federal court to address these cases has rejected them. The Pennsylvania cases are simply based upon a misunderstanding of the breadth of the term "relate to", a misunderstanding specifically noted and rejected by the Seventh Circuit in *Lister*.

Appendix C

The *Bartholet* court noted when rejecting Bartholet's argument that his claims were not removable because they were not related to an ERISA plan:

> Thomas Reed Powell defined the legal mind as one that can think of something inextricably connected to something else, without thinking of what it is connected to. Not even the most segmented mind could contemplate the benefit without the plan.

Indirect Effect on Plan

Plaintiff contends in her Motion for Remand that the state law claims affect the Plan only indirectly. However, this contention, even if true, does not avoid the expansive language of Section 514.

In *Stuart Circle Hospital Corp. v. Aetna Health Management*, 15 EBC 1934 (E.D. Va. 1992), *Aetna* operated a health maintenance agreement (HMO) and was the insurer/ administrator of an ERISA plan which provided medical benefits through the HMO. Aetna had chosen not to allow Stuart Circle Hospital to participate in the HMO. The hospital sued, attempting to enforce a Virginia statute that provided PPOs could not discriminate against whom they allowed to join.

The District Court held that the state statute was preempted. After reviewing the broad scope of ERISA's preemption provision, the court held:

> So long as a state law has a 'connection with or reference to' an employee benefit plan, then the law relates to the plan, and it is of no consequence whether the effect on the plan is direct or indirect. *15 EBC at 1937.*

The court held the Virginia law was preempted.

An Illinois law that allows an ERISA plan administrator/fiduciary to be subject to the liability for directing a patient's healthcare in order to maximize profits for the Plan and affect optimum delivery of care, has both a connection with and affects that Plan directly. A Plan administrator who relies upon the unanimous case law which provides it can be held liable only for those benefits specifically provided in the ERISA plan it administers, could now find itself, as a result of its administering the ERISA plan, facing unlimited liability under state law statutes and theories. In such a scenario, it is ludicrous to argue that such state law claims have no connection to the ERISA plan or that they only affect the ERISA plan indirectly as plaintiff asserts here.

The proposition put forth by the plaintiff in the Motion to Remand was similarly discussed by Justice O'Connor in *Ingersoll-Rand v. McClendon,* 498 U.S. 133, 138 (1991). Justice O'Connor explained:

> The preemption clause is conspicuous for its breadth. Its deliberately expansive language was designed to establish pension plan regulation as exclusively a federal concern. [citations omitted] The key to Section 514 is found in the words

> "relate to." Congress used those words in their broad sense, rejecting more limited pre-emption language that would have made the clause "applicable only to state laws relating to the specific subjects, covered by ERISA." [citation omitted] Moreover, to underscore its intent that Section 514(a) be expansively applied, Congress used equally broad language in defining the "state law" that would be preempted . . . A law "relates to" an employee benefit, in the normal sense of the phrase, if it has a connection with or reference to such plan.

In *Holland v. Burlington Industries, Inc.*, 772 F. 2d 1140 (4th Cir. 1985), *aff'd. sub nom., Brooks v. Burlington Industries, Inc.*, 477 U.S. 903 (1986), the court acknowledged that ERISA was the most sweeping federal preemption statute ever enacted by Congress and, relying upon *Alessi v. Rabestos-Manhattan, Inc.*, 451 U.S. 504 (1981), stated that the only state laws not preempted were those specifically exempted from preemption by Section 514. 772 F. 2d at 1146-47. In the recent case of *Talamine v. Unum Life Insurance Co. of America,* 1992 U.S. Dist. Lexis 14372 (N.D. Ill. September 24, 1992), the court again acknowledged the "sweeping breadth" of Section 514 and noted that the Supreme Court had consistently "expansively interpreted" the preemptive scope of ERISA.

A somewhat more detailed approach was taken by the Eighth Circuit in *Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital,* 947 F. 2d 1341 (8th Cir. 1991), *cert. den'd.*, 112 S. Ct. 2305 (1992). The court there identified various

factors that should be examined in determining whether or not a plaintiff's claims "relate to" an ERISA plan. Applying each of the factors identified by the Eighth Circuit to the facts of this case, it is clear that Cynthia Herdrich's claims relate to the Plan because her claims would: (1) significantly impact the relationship between Plan participant and Plan administrator as the Plan administrator would become the guarantor of the quality of care paid for by the Plan; (2) would considerably increase the administrative burdens of the Plan who would have to develop and enforce an entirely new and burdensome system whereby it would oversee and guarantee the medical judgments of the physician; (3) substantially increase the cost of administering the Plan by requiring the oversight system described above and by requiring the Plan administrator's budget for risk of breach of claims for breach of bad faith and fair dealing, as well as fraud; (4) dramatically affect the statutory scheme which was intended to assure Plan sponsors and fiduciaries that they would have the freedom to develop their ERISA plans as they choose, thereby limiting their liability.

In the case now before this Court, it is clear that the plaintiff's claims relate to the Plan administered by Health Alliance. The relationship between the plaintiff and Health Alliance arose solely from the Plan. But for the existence of the Plan, Cynthia Herdrich's participation in that Plan and Health Alliance's serving as administrator/fiduciary of that Plan, there would be no relationship whatsoever between Cynthia Herdrich and Health Alliance and thus no lawsuit.

Moreover, the claims against Carle Clinic, P.C. relating to fraud arise solely out of the relationship between Carle

Clinic, P.C. and the plaintiff and their collective relationship to Health Alliance. In light of the foregoing, the plaintiff cannot seriously contend that her claims are not related to the Plan.

In short, because the plaintiff is a participant/beneficiary of the Plan, and because she is asserting claims related to the Plan against the Plan's fiduciary and administrator, their claims are clearly within the preemption provision of Section 514. *Ingersoll-Rand v. McClendon, supra.*

Respectfully Submitted,

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION, and HEALTH ALLIANCE MEDICAL PLANS, INC., Defendants,

BY: LIVINGSTON, BARGER, BRANDT & SCHROEDER

BY:
one of their attorneys

APPENDIX D — ANNUAL STATEMENT OF HEALTH ALLIANCE MEDICAL PLANS, INC.

LIFE AND ACCIDENT AND HEALTH COMPANIES — ASSOCIATION EDITION

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ANNUAL STATEMENT
For the Year Ended December 31, 1992
OF THE CONDITION AND AFFAIRS OF THE
Health Alliance Medical Plans, Inc.

NAIC Group Code 000 NAIC Company Code 77950
Employer's ID Number 37-1260731

Organized under the Laws of the State of Illinois, made to the **INSURANCE DEPARTMENT OF THE STATE OF**

PURSUANT TO THE LAWS THEREOF

Incorporated November 17, 1989 Commenced Business December 1, 1989

Statutory Home Office 602 W. University Avenue (Street and Number), Urbana, Illinois 61801 (City or Town, State and Zip Code)

Main Administrative Office 102 E. Main Street, Suite 200, P.O. Box 6003 (Street and Number), Urbana, IL 61801 (City or Town, State and Zip Code) 217 337-8010 (Area Code) (Telephone Number)

Mail Address 102 E. Main Street, Ste. 200, P.O. Box 6003 (Street and Number or P.O. Box), Urbana, Illinois 61801 (City or Town, State and Zip Code)

Primary Location of Books and Records 102 E. Main Street, Suite 200 (Street and Number), Urbana, IL 61801 (City or Town, State and Zip Code) 217 337-8000 (Area Code) (Telephone Number)

Annual Statement Contact Person and Phone Number
Lynn A. Rice 217 337-8241

OFFICERS

President
John W. Pollard, MD

Executive Dir.
C. Carleton King

Secretary
Alan K. Hatfield, MD

Medical Dir.
Benjamin H. Robbins, Jr., MD

Vice Presidents
Martha A. Baddour
Judith A. Griffith
Jeffrey C. Ingrum

DIRECTORS OR TRUSTEES

Robert M. Scully, MD
Barbara A. Kammer, MD
Alan K. Hatfield, MD
Terry R. Noonan, MD
Thomas C. Schrepfer, MD
Robert J. Turngren, MD
John W. Pollard, MD

Appendix D

STATE OF Illinois)
) ss.
COUNTY OF Champaign)

John R. Pollard MD, President, **Alan K. Hatfield, MD**, Secretary, . . . of the **Health Alliance Medical Plans, Inc.**, being first duly sworn, deposes and says that they are the above described officers of the said insurer, and that on the thirty-first day of December last, all of the herein described assets were the absolute property of the said insurer, free and clear from any liens or claims thereon, except as herein stated, and that this annual statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to are a full and true statement of all the assets and liabilities and of the condition and affairs of the said insurer as of the thirty-first day of December last, and of its income and deductions therefrom for the year ended on that date, and have been completed in accordance with the NAIC annual statement instructions and accounting practices and procedures manuals except to the extent that: (1) state law may differ; or (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively.

s/ John W. Pollard, MD
President

s/ Alan K. Hatfield, MD
Secretary

* * *

(a) is this an original filing? yes [x]

* * *

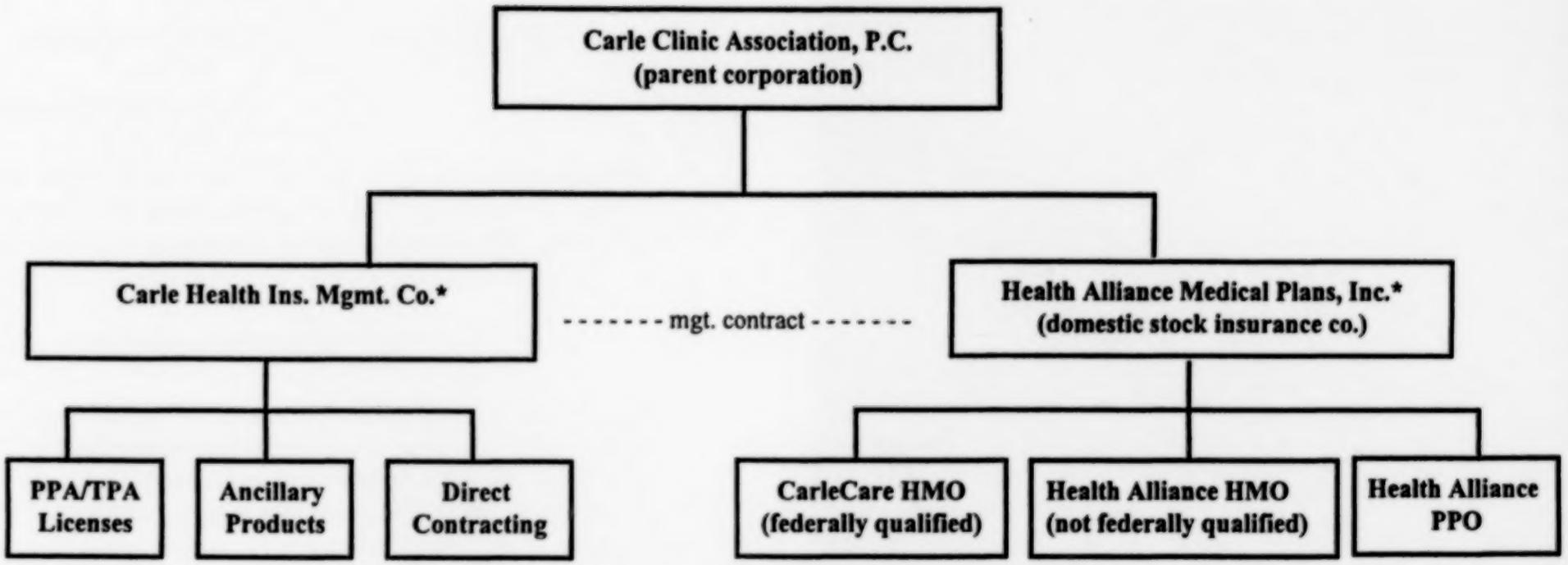
Appendix D

Subscribed and sworn to before
me this 8th day of March, 1993.

s/ Marsha Diane Eversole
notary public

APPENDIX E — PART 1 — ORGANIZATIONAL CHART

PART 1 – ORGANIZATIONAL CHART



• for-profit wholly-owned subsidiary of Carle Clinic Association, P.C.

APPENDIX F — NOTES TO FINANCIAL STATEMENTS OF HEALTH ALLIANCE MEDICAL PLANS, INC.

ANNUAL STATEMENT OF HEALTH ALLIANCE MEDICAL PLANS

NOTES TO FINANCIAL STATEMENTS

1. Basis of Presentation:

   The accompanying financial statements have been prepared in conformity with accounting practices prescribed or permitted by the National Association of Insurance Commissioners and the State of Illinois.

2. Basis of Valuation of Invested Assets:

   A. Asset values are generally stated as follows: Invested cash includes short-term investments which are stated at cost. Short-term investments totaled $109,963. Long-term investments are stated at the lower of cost or market value. Long-term investments totaled $5,841,839. The effective interest method was used for the Amortization of bonds.

   B. Purchased computer software is recorded at cost and is amortized using the straight-line method over 3 years. Furniture and equipment is recorded at cost and is depreciated using the MACRS method over periods of 5 and 7 years.

   C. Not applicable.

Appendix F

3. Investment Income:

   No category of investment income has been deducted or excluded (non-admitted) on any investment.

4. Federal Income Tax Allocation:

   A. The Company files a consolidated Income Tax return with the following companies:

      Carle Clinic Association
      Carle Health Insurance Management Company

   B. The Company and the Clinic have agreed that the consolidated tax liability for any given year will be allocated to those companies that have taxable income during such year in proportion to their relative taxable incomes. Similarly, consolidated tax benefits are allocated to those companies that have taxable losses which give rise to the benefit in proportion to their relative taxable losses.

   Intercompany tax balances are settled annually in the fourth quarter.

APPENDIX G — MINUTES OF APRIL 6, 1992 OF THE ANNUAL MEETING OF HEALTH ALLIANCE MEDICAL PLANS, INC.

MINUTES
HEALTH ALLIANCE MEDICAL PLANS, INC.
ANNUAL MEETING

The Board of Directors of Health Alliance Medical Plans, Inc. ("Health Alliance") met on Monday, April 6, 1992 at 3:30 p.m. in the North Tower 1 Board Room. The following Directors were present: Drs. Scully, Noonan, Parker, Schrepfer, Hatfield, Kammer, and Pollard; Staff present: Dr. Parker; and Messrs. Bash, Green, and King.

Dr. Scully, Chairman, called the meeting to order and noted that a quorum was present. It was moved, seconded and passed to approve the minutes of the March 18, 1991 Annual Meeting as submitted.

Pursuant to Article III, Section 2 of Health Alliance's corporate bylaws as amended in 1991, an appointment to the Board of Governors of Carle Clinic Association, P.C. results in an automatic appointment to the Board of Directors of Health Alliance. Therefore, no elections at Health Alliance's Annual Meeting are required. Dr. Noonan was recognized as a new Director for the record.

It was moved, seconded, and passed to appoint the following individual as Officers of Health Alliance's Board of Directors:

Robert M. Scully, MD, Chairman
Thomas C. Schrepfer, MD, Vice-Chairman
Terry R. Noonan, MD, Secretary-Treasurer
John W. Pollard, MD, President

Appendix G

It was moved, seconded, and passed to appoint the Corporate Officers of Health Alliance assigned by Carle Health Insurance Management Company pursuant to the Management Services Agreement between the two organizations. These individuals are authorized to sign checks, enter into contracts and conduct business on behalf of Health Alliance:

John W. Pollard, MD, President
Benjamin H. Robbins, MD, Medical Director
Joseph C. Barkmeier, MD, Associate Medical Director
Kenneth G. Bash, Assistant Treasurer
Richard D. Green, Assistant Secretary
C. Carleton King, Executive Director
Jeffrey C. Ingrum, Vice-President of Finance
Martha A. Baddour, RN, Vice-President of Health Services
Judy A. Griffith, Vice-President of Operations

The need to indemnify (hold harmless) members of the HMO Advisory Board (a.k.a. Patient Satisfaction Committee) serving at the request of the corporation against threatened, pending or completed actions, suits or proceedings was discussed. It was moved, seconded and passed to amend Article VII of the by-laws to indemnify HMO Advisory Board members meeting the applicable standards of conduct in the same manner in which directors, officers, employees and agents are indemnified.